ATTENDING PHYSICIAN'S SUPPLEMENTAL STATEMENT
ACCIDENT OR SICKNESS

Please Answer All Questions

TO BE COMPLETED BY ATTENDING PHYSICIAN

1. DIAGNOSIS (including any complications)
   a. Diagnosis (including any complications) PANCREATIC ISLET CELL CANCER WITH LIVER METASTASES
   b. Subjective symptoms DIARRHEA / FATIGUE
   c. Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings) ABNORMAL OCTREOTIDE SCAN OF LIVER

2. DATES OF TREATMENT
   a. Date of last visit Mo. 5 Day 17 1/2001
   b. Frequency ☐ Weekly ☑ Monthly ☐ Other (Specify)

3. NATURE OF TREATMENT (Including Surgery and medications prescribed, if any)
   MONTHLY SANDOSTATIN

4. PROGRESS
   a. Has patient ☐ Recovered? ☑ Improved? ☐ Unchanged? ☐ Retrogressed?
   b. Is patient ☑ Ambulatory? ☐ House Confined? ☐ Bed confined? ☐ Hospital confined?
   c. Has patient been hospital confined? ☑ Yes ☐ No If yes, give Name and Address of Hospital UNIV. WISCONSIN - MADISON - SURGERY
      Confined from _____ through 6/01

5. CARDIAC (If Applicable)
   a. Functional capacity ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation) ☐ Class (Marked limitation) ☐ Class 4 (Complete limitation)
      (American Heart Association)
   b. Blood Pressure (last visit) _____ systolic/diastolic N.A.

6. RESTRICTIONS (what the patient SHOULD NOT do) LIMITATIONS (what the patient CANNOT do)

7. MENTAL IMPAIRMENT (if applicable) Provide 5 AXIS Diagnosis
   I.
   II.
   III.
   IV.
   V.
   Remarks:

8. PROGNOSIS

	PATIENT'S JOB	ANY OTHER WORK
a. Is patient now totally disabled?	☑ Yes ☐ No	☑ Yes ☐ No
b. What duties of patient's job is he/she incapable of performing?		
Do you expect a fundamental or marked change in the future?	☐ Yes ☑ No	☐ Yes ☑ No
1. If yes, when will patient recover sufficiently to perform duties Mo. Day Yr.	☐ 1 Mo. ☐ 3-6 Mos. ☐ 1-3 Mos. ☐ Never	☐ 1 Mo. ☐ 3-6 Mos. ☐ 1-3 Mos. ☐ Never
2. If no, please explain		

9. REHABILITATION

	PATIENT'S JOB	ANY OTHER WORK
a. Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.)	☐ Yes ☑ No	☐ Yes ☑ No
b. If employer can accommodate patient's limitations and restrictions is patient able to return to work?	☐ Yes ☑ No	
c. What date would employment begin? _____	☐ Full-time ☐ Part-time	
d. Would vocational counseling and/or retraining be recommended?	☐ Yes ☐ No	

10. REMARKS THIS PATIENT HAS AN ISOLATED METASTATIC CANCER

Physician Name (Please Print) MICHAEL COCHRAN MD Degree

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Signature (No Stamp) M Coch Tax ID No. Date 1/2/01